

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ohanalani L.L.C.	CHAPTER 100.1
Address: 5339 Oio Drive, Honolulu, Hawaii 96821	Inspection Date: October 18, 2019 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u></p> <p><input type="checkbox"/> 9(b) SCG #7, incomplete tuberculosis clearance for new hire. NO evidence of two-step tuberculosis test.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>- A copy of 2nd step PPD from new hire received and filed in the care home folder.</p>	<p>10/18/19</p> <p>19 OCT 32 AM 13</p> <p>STATE OF CONNECTICUT EDUCATION STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<u>1</u> <u>FINDINGS</u>	<p align="center">PART 2</p> <p align="center"><u>FUTURE PLAN</u></p> <p align="center">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>- Will follow checklist for new hire requirements.</p> <p>- Will assign one of my SCG to check all staff record for completion.</p>	<p align="center">10/18/19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><u>FINDINGS</u> Resident #1, no menu to match special diet order "Regular Mechanical Soft" diet.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <ul style="list-style-type: none"> - Called nutritionist and was given guidance on developing regular special diet (mechanical soft). - Made changes on the menu and implemented changes. 	<p>10/22/19</p> <p>19 OCT 32 AM 13</p> <p>STATE OF MICHIGAN DEPT. OF HEALTH STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p> <p>FINDINGS Resident #1, no evidence of Case Manager/ RN training for substitute care givers upon admission.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <ul style="list-style-type: none"> - notified case Manager (CM) of deficiency. - CM and PCG demonstrated proper suppository use to substitute care givers (SCG). - Training for all SCGs completed and filed 	<p>10/23/19</p> <p>19 OCT 32 AM 1:13</p> <p>STATE LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;</p> <p>FINDINGS Resident #1's care plan for ADLS/Dental or Aspiration did not reflect loss of two (2) front teeth (July 2019) and increased risk for aspiration.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>- Notified cm and made changes to care plan to reflect loss of 2 front teeth and increased risk for aspiration.</p>	<p>10/23/19</p> <p>19 OCT 32 AM 13</p> <p>STATE OF CONNECTICUT DEPARTMENT OF STATE LICENSING</p>

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Licensee's/Administrator's Signature: Nora V. Soriano Trias

Print Name: NORA V. SORIANO-TRIAS

Date: 10/31/19

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